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ABSTRACT

Evaluation of child-centered families with mentally retarded children has generated a body of theory based on new concepts of these families. Evidence suggests that relational processes interfering with functional structure in these families also give rise to significant emotional development problems for the retarded child. In turn, symptoms are produced and supported in all family members. Child-centeredness, as an expression of dysfunctional family development, exhibits itself as a family's depending on the child's condition (i.e., mental retardation). For the parents, this provides opportunities to avoid personal and marital confrontation because all concerns must be centered on the retarded child. Deviant interactional marriage patterns such as a conflict-loaded marriage may give rise to child-centeredness. The children may exhibit special symptoms and problems with emotional development, in addition to the problems normally accompanying mental retardation. Family therapy is a useful intervention for treatment of these dysfunctional families. (A case study and references are provided). (ABL)

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A REPORT ON THE EVALUATION MODEL AND FINDINGS RESULTING FROM CLINICAL WORK WITH EIGHT CHILD-CENTERED FAMILIES AND THEIR MENTALLY RETARDED CHILDREN

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Foreword

I will discuss a subject that has interested me for a long time - that of the dysfunctional relational dynamics in families where a mentally retarded child has become the focal point for family development. At Meyer Children's Rehabilitation Institute, my role is that of family psychotherapist to the handicapped children and their families we serve. Over and over I have been struck with the family structure that emerges in some of these families where there is a mentally retarded child. I have used the data from six long-term treatment families to generate this paper, but I will discuss the case history of only one of them, one which seems to illustrate my points quite well.

My interest in the functional development of families with mentally retarded children began five years ago when I collaborated on a study of those factors effecting positive family adaptation to such children. Such factors as community support, a helpful pediatrician, the birth order of child, and many other externals were examined.

After this, additional family study led me down another path, and I began to consider the role played by the mental health each parent brings to the marriage and to the subsequent birth of a child. More and more I have become convinced that this is the pivotal element in functional family development of families with handicapped children. As I began to consider the entire concept of child-centered families, the role of the personal "needy-ness" of the parents became more clear. With the

birth of a mentally retarded child, the stage may be set for a child-centered process to begin to evolve.

A REPORT ON THE EVALUATION MODEL AND FINDINGS RESULTING FROM CLINICAL WORK WITH EIGHT CHILD-CENTERED FAMILIES AND THEIR MENTALLY RETARDED CHILDREN

Introduction:

Evaluation of child-centered families with mentally retarded children has generated a body of theory based on new concepts of these families. These concepts describe such child-centered families, give the professional ways to identify them, and provide techniques to treat them as well.

Our interest in these child-centered families with mentally retarded children stems from evidence that the relational processes interfering with functional structure in these families also give rise to significant emotional developmental problems for the retarded child. In turn, symptoms are produced and supported in all family members.

Child-centeredness, as an expression of dysfunctional family development, exhibits itself as a family's dependency on the child's condition (i.e., mental retardation) and then, for the parents, provides opportunities to avoid personal and marital confrontation because all concerns "must be centered" on the retarded child. Subsequently, "needy" parents learn to seek companionship and gratification from the child who "needs" them. The mental retardation thus becomes an element in the child-centering process.

I will report briefly on a family therapy (or systemic) evaluation model and several years of work with child-centered

families with mentally retarded children and the relational processes which give rise to the dysfunctional family structures in such families.

Family Therapy, although universally known, is not yet a fundamental method, and so to provide a base for the concepts I will discuss, I would see it as appropriate to clarify the meaning I attach to this mode of evaluation, due to the rather loose application of the word "Family Therapy" - ranging all the way from: 1) multiple family members attend the session without regard for a method or technique, to; 2) therapy associated with general systems theory. The terms system theory and system therapy are really more accurate than family therapy, especially when they refer to problems emerging as a result of family relationships. Basic to the theory, of course, is the premise that a family is a system, in that a change in functioning of one family member is automatically followed by a compensatory change in another family member. (Bowen, 1974)

While family therapy (or systems therapy) centers on the functioning of a family system, if we use the analogy of a biological system, the Human Body, the elements associated with the concept of a child-focused family emerge clearly. The whole organism is composed of a number of organ systems. A complex set of automatic devices controls the smooth reciprocal operation of vital functions of these organs. The systems then may function at all levels of performance from very healthy to total breakdown. There are vigorous states in which an organ can

increase its capacity to take care of an increased burden. There are also conditions in which an organ loses the ability to handle a heavier load. One system escalates its capacity to make up for the decreased functioning of another. Additionally these states of dyscapacity may range from short acute through long chronic illness, even to permanent impairment in a system. Organs that function for others for a long period of time experience difficulty returning to normal. A weakening organ works faster and harder in a futile effort to surmount its overload, (e.g., the racing of a worn out heart as it approaches total failure). (Bowen, 1974.)

This same pattern of compensate, overcompensate, and dyscompensate is visible in the way family members relate to one another. For example, the underfunctioning of a family member who is ill or absent will be made up for by other members who overcompensate until the load is balanced again. If the absent or sick member becomes chronically or permanently disabled or does not return, the overcompensation of the others may become permanent. The overfunctioning of some members will cause underfunctioning in others. (Bowen, 1974.) To be aware of the problems these patterns generate, support and maintain, we must first know what child-focused families are and how they operate, as well as how they originate and what keeps them functioning in such styles. How can we recognize them and how do they express themselves?

"Families, we know, are not static units, but are continually changing in the ways of systems. It follows then, of course, that a child-focused family is not a type of family but rather an expression of deviant family development." (Haley, 1974.) We also know that at some point in a family life cycle, child-centeredness is not only characteristic but is necessary for the survival of the totally dependent child. Normal family development mandates this characteristic decrease as children develop, and as their needs become fewer. Therefore, we can identify child-focusedness then as a dysfunctional structure. By using child-centering devices, families produce developmental problems with different degrees of damaged emotional function in children, but leading in most cases ultimately to symptom production. (Barragan, 1974.) A family, according to Bradt and Moynihan, "then become preoccupied with its members, (e.g., a mentally retarded child) as if life and the elements of life depend on the definition of a child." They also note, "The child-concerns of such parents supercede reality, and supercede self-functioning and responsibility to each other and to the extended family and finally to the community."

The elements in this child-focused process emerge with the passage of time. There are the predisposing factors that existed before the problems of child-focusedness became evident, and there are those continuing elements which tend to crystallize the cycle of focusedness. Together, these tend to create the operation of a dysfunctional non-fluid system as they interfere

with change and maintain a cycle of dysfunctional family development, one ultimately responsible for the child-focusedness and lack of growth in the family's life. Three issues are prominent in the previously existing elements: 1) the nuclear families of the parents with their cultural heritages, 2) the individual personalities of each of the parents, and 3) how the couple operated in mutuality before the children were born. (Barragan, 1974.)

The parent's personalities and their capacity for interpersonal relationships are of interest. Often we find parents "focusing" on their mentally retarded children in an attempt to give them what they have not had but desired. Such deficiencies, says Barragan, are "products of early interactions with their own families that were either insufficiently nurtured or distorted." Hanna Gavron (1966) says, "Only in the context of a growing mutual base to the marital relationship can one find a tendency in parents to establish some healthy barriers between themselves and their children." Before children are born, spouses should ideally have a situation that includes three areas, according to Berman and Lief, "Power: who is in charge? Intimacy: how near, how far? and Inclusion-Exclusion: ... the who or what else is considered to be part of the marital system - for instance, in-laws, careers, and activities" in healthy relationships. The answers are not fixed, but constantly change.

Dysfunctional spouses on the other hand use more non-flexible solutions. Barragan goes on to say that optimal

conditions for child-centeredness in families will occur when the couple has not adequately dealt with these three issues and has to adapt to each other's ways at the same time they are emancipating from their families of origin. It is clear that the parents of a mentally retarded child may have the same built-in predisposing factors. Family deterioration at this point can be defined by intrusion of parents-in-law, often under a mantle of financial or emotional support.

The more parents focus on their retarded child, the easier it becomes to ignore marital problems because there is always something to discuss, denounce, find fault with, or dread. Parents develop a dependency on the children's symptoms and tenaciously resist giving them up. Many such families get family unity by scapegoating the retarded child. (Vogel and Bell, 1961.)

Several deviant interactional patterns in marriages may give rise to such child-centeredness. The first of these is the conflict-loaded marriage, tense and unpleasant, with the parents together out of fear of loneliness. In the devitalized marriage, the relationship is characterized by apathy. It is conflict free and devoid of vitality. It is usually held together by legal/moral bonds and children. The passive, congenial marriage is pleasant but uninvolved, and receives its supports from outside the family. (Cuber and Harroff, 1966.)

One of the rules of systems theory dictates that "anyone in a dual role tends to compensate for dissatisfaction with one of

the roles, by perfecting or by over-developing the other." (Barragan, 1974.) The arrival of a mentally retarded child in a family where there is conflict between parents, presents fertile opportunity for these dissatisfied spouses to over-develop as parents in order to compensate for their unhappiness with one another. And, since parenting mentally retarded children is often measured by how successful the children are, an unhappy parent may set forth on a job of raising a perfect retarded child. Barragan continues, parents may then justify their deficiencies as spouses by telling themselves they are sacrificing for the happiness of their children.

Centering on a mentally retarded child gives rise to symptoms and problems with emotional development, as well as with those problems normally accompanying mental retardation. The children show even more defective autonomy, and show, as well, the consequences of over-parenting or their parents' hostility. The mentally retarded child's behavioral and emotional symptoms defy being focused on, but at the same time serve to promote and maintain the dysfunctional relationship patterns.

As Barragan says, the choice of the child's behavioral and emotional symptoms in a child-focused family may be determined by several elements, how the parents express their child-focus and how the child gets involved in the executive conflict. He describes the symptom development occurring in several different patterns. The first can be defined as a "stable coalition," of which the symptom in the child may be anxiety. In this pattern,

the parents are in conflict and the child is allied with one, usually the mother. The distant parent attempts to enlist the loyalty of the child, but with no results. This parent may eventually give up and distance, or may keep trying. The second pattern is defined as a "detouring-attacking" pattern in which the symptoms in the child may express themselves as behavior problems. In this pattern there is conflict between the parents who unite against the child and who define the child as a "family problem", or "bad".

There may also be a third "detouring, over-protection" pattern in which the child's emotional symptoms are insecurity or shyness. In this pattern the parents are in conflict, and unite by mutually over-protecting the child who is described as "weak".

A final pattern, that of "triangulation" shows the parents in conflict, with each of them seeking an alliance with the child, and wanting the child's loyalty. Thus it is impossible for the child to be loyal to one parent without being disloyal to the other. The basic tension exists between the parents with the father gaining an outside position and often being passive and distant and leaving the conflict between the mother and child. The mother is often called aggressive, dominating, and castrating, and the child and the family then move another step toward chronic functional impairment. Families with a retarded child may replay this triangular game over and over for years but the final result is always the same. Over the years, the mentally retarded child accepts the lose outcome more easily,

even finally to the point of volunteering for the position. A variation in the pattern is one in which the father attacks the mother leaving the child in the outside position. This child then learns the techniques of gaining the outside position by playing the parents off against one another.

When a child is mentally retarded, its parents often disagree on how to deal with problems. The parents may then utilize this child as the focus in their relationship and communicate with one another by talking about the child, enabling one to criticize the other without confronting or being critical of their relationship itself. The child then may support this dysfunctional pattern with symptomatic behavior. For example, by insisting that their problem is their mentally retarded child, the parents deflect their attention away from personal problems. The conflict between husband and wife is avoided by constantly reinforcing dysfunctional transactions in the parent-child relationship. This behavior then serves to maintain the only system balance at present acceptable to all components of the system.

When a child-focused structure is held in place by its maintaining and supporting patterns, the family will always be centering on child events and issues and they may be overly involved in doing a "good job". The parents function constantly as parents rather than as adults with identities separate from their children and actively participate in many parent organizations. Little social life with other couples is enjoyed,

and the primary recreational activities in which they engage will be with their child. Budgeting for the child's needs dictates financial allocation. The child normally has excessive amounts of clothes and toys. A particular special education program may be over-emphasized and the parents' choice of housing may be only coordinated with school choices. (Barragan, 1974.)

The family I wish to discuss presented as a child-focused family with four children, three boys and one girl. The parents were in their late 40's. Of the four children, two were diagnosed as trainable mentally retarded, the older, a son who was 17, and the younger, a 12 year old daughter. The problem reported at the time of this family's referral to me was primarily centered in the 12 year old daughter, but was defined as a marital problem by the mother who reported difficulties in this area to the child's pediatrician. The pediatrician suggested that she call me.

When Mrs. D. phoned me, she expressed doubt that her husband would agree to come for an interview but agreed to request this, and the parents were subsequently seen together. At this time, the symptoms were recounted by them in a joint interview.

The primary problem defined by Mr. D. was the lack of sexual activity in the marriage and his resentment about his wife sleeping on the couch in the living room. He also listed a number of complaints about the "dirty" condition of their house, his wife's excessive drinking, the undone laundry, and his wife's physical neglect of herself and of their retarded daughter. Mrs.

D.'s complaints were about her husband's physical and emotional distancing, and his volunteer work with the Fire Department and other outside interests which kept him away from the house several evenings a week. She reported that her husband did not help her with their daughter and that this child, because she was non-ambulatory, was a considerable physical burden.

In this family, the mother was in the distant critical emotional position, and the father emotionally over-involved with his daughter and reactively distant from his wife, a stable coalition. Since the daughter was sensitive to the mother's distance and especially tuned into her father's anxiety level regarding her own situation, an increase in either the distance or the anxiety would predictably increase her symptomatic behavior. This consisted of mouth noises, vocal demonstrations, whining, and restless turning from one side to another. She would also refuse to eat.

A child-focused family with a mentally retarded child may present for assessment and treatment with the symptoms in the child, or the family may present with a marital focus with open conflict and on the verge of divorce, or with just a communication breakdown. A family may also present with emotional or physical symptoms in one or the other of the spouses, and, in very rare instances, a family may present with an extended family problem as well.

Mr. and Mrs. D. were worried about a decision regarding the impending placement of their daughter in an institution. Their

opposite and different perspectives about this were process issues of their marriage, and when the family came to the Institute, the mother had already begun to embark on the process of restructuring the family system in a way that would, she believed, help her to repair her marriage. The distance (identified as neglect) she exhibited from her daughter provided reciprocity for the over-involvement of her husband and this child. Both these parents were relationship-oriented, emotional externalizers. However, neither had learned, during their nearly 20 years of marriage, to directly express their feelings, needs, and desires to one another. While the father was emotionally close with his daughter, he maintained a physically distant, critical expert position in relation to the job his wife was doing with the house and children. He was very much into his own business and projects, whereas, she was under-functioning and really distant from a lot of the family busy work.

In order to set the stage for restructuring the process in this family triangle and thus shifting the symptom, the parents were ordered, paradoxically, to stay hurt, and to hold on to their negative feelings, as "they have kept you together for 20 years and must be serving a useful purpose". The ensuing reconciliation included the resumption of the pair putting on their wedding rings again, with a warning from their therapist that "it can't possibly last," and they should be ready for things to get difficult again. At this point, the parents agreed

to delay the issue of their daughter's placement while they continued to work on their improving marriage.

This stage of intervention was intended to focus attention on the real issues, sure to arise again. The intensity of family therapy escalated as did the intensity of the marriage relationship, during this second stage of intervention.

Before I could give any further instructive intervention to exacerbate the original marital symptom of distance, Mrs. D. took matters into her own hands once again, albeit indirectly, and secured for herself a "driving-while-intoxicated" citation. The ensuing dynamics included the mother's separation/move into an apartment, the father's frightening and reactionary, histrionic collapse in her living room, and her subsequent inpatient treatment in a psychiatric facility. During her stay there, she confessed to Mr. D. that she had also had an affair.

Mr. D. was now forced to move into the role previously occupied by her at home, as he cooked, cleaned, did laundry and cared for this taxing family. He at once hired some help for the children and secured respite care for the two handicapped children on the weekends.

The father, without instruction as his wife distanced more, began to move into a position of pursuer. As long as his wife had been where she was "supposed" to be, he could be absent and do his thing, but as soon as she was gone, his anxiety increased as did his somatic symptoms. Mr. D. began to question whether

his distance and over-involvement with his daughter weren't things that were affecting the family negatively.

When he sat in my office weeping and said, "She (his daughter) was getting to be too much; I transferred my love for my wife to my daughter, so I wouldn't have to give her up," I knew the primary change had occurred. The process had shifted, and the problem had been redefined and systematized, with the locating of the symptom in the marriage.

Not all families engage. Some fail to embark on such a long-term course, not having the energy or courage for it. Others may sabotage interventions or withdraw after the initial intervention and subsequent relief.

The D. family was now free to choose, during this last stage of intervention, to plan for the necessary and critical placement of their two handicapped children. As soon as the mother was ready to change, new pathways and options were available for the whole system of relationships. The last time I heard from the D. family, it was in the form of an invitation to be present at the ceremony of their marriage vows renewal.

I want to point out that the structural tasks I have used and briefly described did not attempt to modify the family's values. Instead the attempt was to restore stability to a system defined by structural dysfunction. Awareness of the presence, elements, and characteristics of such child-focused families in our work with them and their mentally retarded children will help us to develop more and more effective ways to work with them as

we meet our twofold goal of assessing and treating the problems of these distressed families.

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